California Health Policy and Data Advisory Commission
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Minutes
AB 524 Technical Advisory Committee
November 9, 2007

The meeting was called to order by Chairperson Jerry Royer at 9:07 a.m., at 400 R Street, Suite 317, Sacramento, California. A quorum (defined as half plus one) was in attendance.

Present:	Absent:
Jerry Royer, MD, MBA, Chair	Marilyn Chow, RN, DNSc
Douglas Bagley, MD	Nancy Donaldson, RN, DN
Mark Hlatky, MD	William Weil, MD
Kathy McCaffrey	Robert Brook, MD, ScD
Elizabeth Carolyn Abbott	Laurie Sobel, J.D.
Laura Gardner, MD, MPH	

OSHPD Staff: David M. Carlisle, MD, PhD, Director; Elizabeth Wied, Chief Counsel; Beth Herse, Sr. Staff Counsel; Michael Rodrian, Deputy Director, Healthcare Information Division; Joseph Parker, PhD, Director, Health Quality and Analysis Division; Jonathan Teague, Manager, Healthcare Information Resources Center; Mary Tran, Phd, MPH, Manager, Patient Discharge Data Programs; Holly Hoegh, Manager, Clinical Data Program; Candace Diamond, Manager, Patient Discharge Data Section; Brian Paciotti, PhD, Research Program Specialist II; Starla Ledbetter, Healthcare Information Division; Susan Olsen, Patient Data Section; Malika Rajapaksa, PhD, Research Scientist II; Serena Beltran, Adminstrative Assistant; Robert Springborn, PhD, Research Scientist II, CABG Program

CHPDAC Staff: Kathleen Maestas, Acting Executive Director; Terrence Nolan, Office Manager

Others Present: Vito Genna, CHPDAC Chair; Kristen Bibbins-Domingo, MD, PhD, University of California, San Francisco; Liz Goldman, MD, MCR, University of California, San Francisco; David Zingmond, MD, University of California, San Francisco; Andrew Bindman, MD (via teleconference)

Approval of Minutes: Committee Member Bagley made a motion to approve the August 3, 2007 Minutes. Committee Member Hlatky seconded. The minutes were unanimously approved by the Committee.

OSHPD Director's Report: Dr. Carlisle reported that there is great concern in state government concerning next year's budget. Fortunately, OSHPD's programs are special fund supported with only a couple of exceptions. The work that the AB 524 Technical Advisory Committee does is entirely special fund supported. But that does not mean that the budget impact would not be felt by the programs.

Currently there are intense healthcare reform discussions going on. There has been some consensus reached, as with the Hospital Association stating their support for the 4 percent facility fee, recognizing that the net benefit to all California would be positive.

AB 8, the Assembly and Senate leadership Healthcare Reform Bill was vetoed by the Governor. That bill contained some specific elements that have relevance to OSHPD as well as the Commission and its committees. It proposed creating a department-level Committee within the Health and Human Services Agency specifically to conduct the data function of OSHPD. This was prompted by discussions with labor groups, consumer groups and an employer organization, the Pacific Business Group on Health, which criticized OSHPD for delays in public reporting and not producing the diversity of reports that had originally be envisioned under the program. Despite the fact that AB 8 has been vetoed, those discussions are ongoing at this point.

Presentation of the New Risk Adjusted Outcomes Model for Congestive Heart Failure: Kirsten Bibbins-Domingo, MD, PhD; Mary Tran, PhD, MPH; Brian Paciotti, PhD

Dr. Tran stated that OSHPD is considering reporting on congestive heart failure (CHF) as it is the second leading cause of hospitalization in California in addition to being of national interest as the Agency for Healthcare Research and Quality (AHRQ) includes CHF in its in-hospital death as an inpatient quality indicator (IQI) mortality measure. There is a wide range of outcomes for CHF patients in California and it is thought that better medical care can lead to better outcomes.

The CHF model has been developed as a benchmark report which has the following features:

- In-hospital outcome used instead of 30-day mortality
- Quality ratings ranked by quintiles
- Univariate associations between risk factors and mortality used to identify additional risk factors beyond what has already been reported in the literature

A definition of CHF was developed based on the AHRQ definition in conjunction with a literature review and the recommendations of Dr. Bibbins-Domingo. Candidate risk factors were identified through a literature review, clinical recommendations, and an empirical analysis, which included a review of diagnoses grouped by Clinical Classification Software (CCS). Risk factors were chosen which had a prevalence of at least .3 percent and a Spearman correlation of CCS with a coefficient of at least .1 percent.

A model was then developed from these candidate risk factors. A logistic regression was used and sets of risk factors were selected. Alternative sets of risk factors were tested to ascertain which additional risk factor actually added to the predicted value of the model. The model was developed with a development sample and the results were compared using a validation sample, with the final results reviewed by a clinical consultant. The model is now being presented to the AB 524 Technical Advisory Committee for discussion and review.

The Data sources are OSHPD patient discharge data, admissions during January 1, 2003 to December 31, 2005. Patient records were linked to death certificate files to test the sensitivity of the model to using in-hospital versus 30-day mortality. An index admission was an admission to a general acute care facility within the study window, the first admission for CHF in that three-year period and CHF had to be present at admission. Exclusions included people who were admitted from skilled nursing facilities (SNFs), transfers out to other acute care facilities, patients younger that 18 years of age, diagnosis related to trauma, and records with data problems.

Committee member Bagley asked if the exclusion criteria included just inpatient transfers or also included emergency department (ED) transfers.

Dr. Bibbins-Domingo stated that it was her understanding that if a patient came from another facility, whether they came from the ED or from an inpatient stay at the other facility, they would not be included in the sample.

Committee member Bagley asked if the exclusion criteria was excluding patients who were already inpatients at a hospital being transferred or was it also excluding patients who were in the ED at that hospital but not yet formally admitted as inpatients and who were transferred.

Dr. Tran stated that there was no way to inspect the data for someone who was only in an ED at another hospital. OSHPD only has coding for somebody who was not an admitted inpatient in another hospital.

Committee member Bagley observed that somebody that was an emergency department transfer from another hospital would included by default.

Dr. Tran agreed stating that that would be considered an admission from home. The focus with this study is a particular episode of care. People who are

transferred in or transferred out have different risk patterns, so they were excluded.

Dr. Bibbins-Domingo explained that congestive heart failure is interesting in that it poses challenges by the chronic nature of the condition, which is punctuated by episodes of admission. Recognizing that a person may have had many prior admissions for heart failure, OSHPD will concentrate on the first index admission during a particular window period. The rationale for that is that there appears to be something about the care during that initial first index admission that is associated with mortality that presumably you can do something about with higher quality of care." This rationale had to do with the fact that OSHPD is focused on in-hospital mortality. This requires excluding people that transferred in or transferred out, because factors about the care they received initially could affect their ultimate outcome.

Dr. Carlisle added that the reason that this is important is that patients that are treated in the emergency room may get credit for some care that they have received before they entered into the hospitalization period that is actually under evaluation which may or may not alter their course.

Dr. Bibbins-Domingo stated that in considering risk factors to select for modeling, she first reviewed a number of published risk adjustment models for heart failure. A parsimonious list was generated of potential conditions that OSHPD should include in a risk adjustment model, as many of them are present in the other published models. An extended list was also generated which contains a number of other potential conditions that are either strongly associated with mortality or are present in some reviewed models.

Parsimonious List:

- Cardiac arrest
- Acute MI
- Shock
- Coma/brain damage
- CVD
- Liver disease
- Acute renal failure
- Nutritional deficiency
- Septicemia
- Hemorrhage
- Fluid/electrolyte disturbance
- Dementia
- Pneumonia
- Cancer
- Anemia
- Adult respiratory failure

Extended List:

- Other circulatory diagnosis
- Intestinal obstruction
- Skin ulcer
- Gangrene
- COPD
- Diabetes

Dr. Paciotti described the CHF cohort results in the risk adjustment models and how the 30-day and in-hospital mortality models compared. Numerous models containing various combinations of clinical and demographic variables were evaluated and the following risk factors were found to be the strongest and most consistent:

- Cardiac arrest OR=27.0
- Shock OR= 9.4
- Intestinal obstruction OR=3.5
- Septicemia OR=3.3
- Coma/brain damage OR=3.3
- Acute renal failure OR=2.8
- Acute respiratory failure OR=2.5

For example, a person who experienced a cardiac arrest that was present on admission was 27 times more likely to die in the hospital than a person who did not have a cardiac arrest. The risk factors in the extended list were independent of the risk factors in the parsimonious list. For example, adding skin ulcers and gangrene to the model did not substantially change the model coefficient and parsimonious list. Chronic diabetes and anemia are protected risk factors when added in a full model with all the parsimonious and extended risk factors, which means that patients are slightly less likely to die with these conditions.

Dr. Carlisle asked if there was any speculation on why anemia and diabetes would be protective when they might at first be thought to have a negative effect.

Dr. Bibbins-Domingo stated that if, for example, diabetes was diagnosed prior to the index admission, it might be considered a marker of being in care. The same explanation might apply to anemia.

Committee member Bagley asked if this effect might also point out a weakness in the model itself regarding the fact that these risk factors show up as being protective when one wouldn't expect that.

Dr. Tran explained that this often happens in multi-variate analyses, that something shows up as protective after you have controlled for all other factors.

Dr. Carlisle added that when it was discovered that using large data sets and multi-variant methods, high blood pressure, which everyone thought was going to be a risk factor, was found to be protective. It turned out that having blood pressure reserved was the physiological reason for that. There may be many physiological reasons why these risk factors are protective and clinical medicine is only starting to learn about them.

Dr. Paciotti explained that C statistics were used to evaluate how well models correctly predicted mortality. For the model with the parsimonious risk factors a C statistic of 78.3 was obtained. Most researchers in the field would consider this to be a well performing model. Adding the risk factors from the extended list to create a full model only increased the C statistic to 78.9. This indicates that the extended list does not add much additional predictive power to the model. By comparison, the CHF model developed by Krumholz for the Centers for Medicare and Medicaid Services (CMS) has a C statistic of 70.0.

Dr. Paciotti presented two graphs; one showing in-hospital mortality for CHF with a state average of 3.49 percent, and the other showing 30-day mortality rates for CHF with a state average of 7.47 percent. The graphs showed hospitals divided into quintiles and both graphs were compared to determine if there were any large differences in how hospitals would place in the quintiles.

Committee member Bagley asked why the quintile approach had been chosen over the statistical outlier approach as there appeared to be very little difference in the middle three quintiles.

Dr. Parker explained that the benchmark approach being used in the model uses a fraction of all the data normally used in gold standard reports, therefore this report is not intended to indicate worse-than-expected or better-than-expected hospitals in the same manner. In addition, consumer groups have indicated that they would like to see more discrimination in the ranking of hospitals.

Committee member Bagley asked if the difference in the middle three quintiles was a statistical difference or an indication that quintiles should not be used as a methodology.

Dr. Parker stated that, because there is a lack of clinical consensus on what constitutes a good risk-adjusted mortality rate for CHF, OSHPD has used the statistical approach with a 95 percent confidence interval. The benchmark report is a departure from that and requires a different mindset. If an individual believes that real differences are only visible with a statistical test, then this approach will probably have little appeal, as it shows its value through a relative ranking.

Dr. Tran explained that the 95 percent confidence interval is used when generalizing a sample to the entire population. In this case OSHPD is not

working with a sample but the entire population. There is a different kind of statistical consideration when you are not testing a hypothesis using a sample.

Dr. Carlisle agreed, adding that P values are really only meaningful if you are comparing a sample to a population. The statistical test is essentially irrelevant when you are working with the entire population. The P value is an artificial test of significance in a situation where a sample is used. If you have the entire population, you don't have to apply a statistical test to determine significance. That is why ranking in this context is actually a fair approach to the model.

Dr. Tran presented the following information pertaining to the use of in-hospital versus 30-day mortality as an outcome:

- Odds ratios for risk factors are about the same in both models
    - ORs higher in the in-hospital death model for cardiac arrest and shock
- C-statistics are very similar for the in-hospital and 30-day mortality outcomes.
    - C=78.9 and C=76.1 respectively
- Recommend: Use the in-hospital mortality model
    - Allows more timely completion of outcomes reports
    - Performance of model is comparable to 30-day model
    - In-hospital model does identify variations in mortality risk across hospitals

Dr. Carlisle stated that OSHPD tends to focus on 30-day mortality because of the intense pressure pertaining to public reporting with respect to the possibility that an institution could alter their performance by rapidly discharging patients, or transferring patients to long-term care facilities. That is why OSHPD tends to look at a fixed mortality period rather the fairly artificial definition, "did it happen in the hospital?"

Dr. Parker added that hospitals with step-down units have an even greater advantage in that they can transfer out very ill patients and the database shows them as discharges so their mortality would not be counted in the new patient mortality measure. The 30-day mortality approach would be a trade-off, more timely reports for a more clinically meaningful report.

Dr. Bibbins-Domingo explained that the focus had been on the in-hospital mortality and that was the reason that transfers in and transfers out had been excluded. If the 30 day approach was used, presumably transfers would be included.

Committee member Hlatky stated that was another good reason to use the 30-day approach.

Dr. Parker asked if he would be correct to state that there is a building consensus of the committee that despite getting a report out earlier using the

inpatient mortality measure, there are problems with it and OSHPD would want to stay with the 30-day mortality measure.

Chairperson Royer agreed that was the indication of the committee members.

Presentation of the Reliability and Validity of Coding in California Patient Discharge Data: Liz Goldman, MD, MCR

The project aims were to assess the reliability and validity of hospitals' self-reporting coding of condition present at admission (CPAA), do not resuscitate (DNR), external cause of injury codes (E-codes) and reabstract all data elements in the OSHPD patient discharge dataset (PDD).

A reliability analysis was conducted consisting of a blind review of the medical record by health information technicians (HIT) which was intended to mimic the process conducted by the hospitals at their own facilities. Then using registered nurses, who come with clinical expertise, a blind evaluation of the CPAA coding after confirming the diagnoses was conducted for the validity analysis.

Overview of Methodology:

- Probability sampling of medical records from year 2005 from acute care hospitals in CA
- Abstractors participated in training and pilot test
- Each record reviewed by HIT and RN
- 250 records double reviewed for inter-rater reliability
- Data collection: June-October, 2007

Four umbrella conditions were selected for sampling because they are common causes of hospitalization, and they are efforts of public reporting. Then they were paired with associated risk factors with high mortality, high incidence and with the ability to be either a preexisting condition or a complication of care. The definitions of umbrella conditions and risk factors were taken from the ICD-9 codes from the OSHPD model for AMI and CAP, and from the AHRQ Inpatient Quality Indicators for CHF and PTCA.

The following umbrella condition/risk-factor combinations were chosen:

- AMI +pulmonary edema
- AMI +shock
- CAP +respiratory failure
- CAP + septicemia
- CHF +AMI
- CHF +acute renal failure
- PTCA +AMI
- PTCA +acute renal failure

A complex sampling design was developed with the goal of creating a sample that could be generalized to the rest of California hospitals. From randomly selected hospitals, a random sample of charts with the umbrella condition and risk factor combinations were taken, from which 10 charts within each combination were reviewed so as not to weigh one hospital more than any other hospital.

Only records where the blind reviews conducted by the HIT exactly matched the ICD-9 code for the umbrella condition and the risk factor, and matched exactly one or one of a cluster of codes that defined the condition.

Preliminary findings:

- HITS coded CPAA as "Yes" as often as Hospitals
- No difference in how often RNs and Hospitals coded CPAA as "Yes"
- RNs and HITs coded CPAA as "Yes" with almost the same frequency
- RNs and Hospitals had similar agreement on CPAA for medical and surgical conditions
- HITs also had similar overall agreement for medical and surgical conditions

Further Analyses:

- Evaluate inter-rater reliability of HIT and RN coding
- Evaluate the potential reasons for differences in HIT and RN CPAA coding
    - Understand reasons for disagreements between RNs and HITs by analyzing the source of the data RNs used to determine CPAA
    - Analyze whether RNs used signs and symptoms of disease that HITs were unable to interpret
- Develop a Gold Standard of CPAA coding
    - Agreement among multiple abstractions provides opportunity to devise a gold standard CPAA evaluation
- Determine validity of CPAA coding for other secondary diagnoses
    - Develop methodology to compare CPAA coding for all other secondary diagnoses (up to 24)
- Apply methodology to DNR and E-Codes

<u>Presentation of Research Design for Modeling Hospital Stroke Outcomes: David Zingmond, MD, PhD</u>

Acute stroke is an important new disease for outcome reporting that OSHPD has not explored until this preliminary study. There are 50,000 stroke hospitalizations per year as compared to 40,000 AMIs which are already being reported. The 30-day mortality for stroke is 16 percent as compared to CHF which is 3 ½ percent. The mortality rate for ischemic stroke is 12 percent and 30 percent for hemorrhagic stroke. In addition, there is also significantly more

disability associated with hemorrhagic stroke because more areas of the brain can potentially be affected.

Stroke differs from some of the other conditions that OSHPD has looked at to date in that it is a heterogeneous presentation, there are specific acute treatments in a specific window required for treatment, there are residual deficits, and symptoms vary depending upon the region of the brain affected. Therefore, it is important to define stroke type and severity before going forward with a study.

The course of the disease is also important. The most severe deficits are in the first two weeks. Patients don't show significant amounts of recovery in the first two weeks. Then going forward, there is a steep sigma curve, where there is a significant recovery, and a plateau at three months after which there is not a significant amount of extra recovery of function. So defining what the sensitive, specific, and appropriate outcomes for a study is important.

The goals of treatment for those that look at stroke care are:

- Acute reversal of (ischemic) Cerebral Vascular Accident (CVA)
- Maximize recovery of function
- Ensure recovery of independence
- Decrease the likelihood of complications
- Reduce the risk for recurrent stroke
- Provide appropriate care at the end-of-life

Currently there are two primary ways of treating ischemic CVA; clot busters (tPA) and cerebral angioplasty. There is no treatment for the reversal of hemorrhagic stroke at this time. Post-acute stroke interventions are common across both types of stroke. All patients are evaluated for rehabilitation, physical therapy and occupational therapy. In addition, in post-acute treatment, attention must be paid to avoidance of complications such as bed sores, pneumonia, and urinary tract infections. Secondary stroke prevention for CVA or prophylaxis for stroke, entails factors such as anticoagulation/anti-platelet therapy, cholesterol lowering agents, tobacco cessation, blood pressure medication and the identification and treatment of anatomic risk factors.

Knowing a patient's wishes and following them is really important in this disease, because many patients come in with coma and severe disability and are potentially unable to make decisions about their treatment and care. Offering, receipt, and following do not resuscitate (DNR) orders are considered measures of quality of care.

Quality improvement efforts to date:

- Development of stroke care guidelines/protocols/recommendations
- Development of quality indicators for stroke care
- Information dissemination programs

Dr. Zingmond presented an analysis of the aims for a stroke outcomes study highlighting the items that would be important to bring people together in backing a stroke outcomes report stating that, “There is no point in putting out reports if the hospitals are going to argue that there is nothing that they can really do about the illness being reported.”

Aims for a Stroke Outcomes Study:

- Establish the validity of diagnoses and procedures in the PDD related to CVA severity, treatment, and outcomes
- Examine variation in quality measures and establish link to mortality
- Examine the use and variation in DNR orders for stroke patients
- Create analytic models predicting mortality to be used for ranking hospitals using PDD
- Prepare a technical report that can be used as a template for public reporting of results

Some Key Study Features:

- Literature review and clinical committee
- Chart abstraction instrument development and implementation
- PDD analysis and case identification for the chart abstraction
- Data analysis
- Report preparation (validation description and outcomes reporting template)

Committee member Hlatky asked if Dr. Zingmond felt that stroke outcomes in general are changed enough by what happens in hospitals, including the best ones, to justify looking at process measures in the form of an outcomes study.

Dr. Zingmond stated that he did a provider survey of 250 stroke hospitals in California in conjunction with two neurologists at UCLA. The team was then able to characterize the structural measures of care and classify hospitals by whether or not they had stroke teams and wards. This provided a way to show that there was a direct link between having a stroke team and ward and decreased mortality. “I think this argues that there are acute clinical things that a physician tends to be the one doing, but there are other things that happen in the hospital, with the nursing staff, with how well the care is delivered that can provide good results.”

Dr. Carlisle agreed, stating that there is a growing body of thought that process of care is important for stroke patients. There is some disagreement as to which particular component of the process of care is important to stroke patients, but the fact that other entities are starting to report on stroke outcomes indicates that there is traction for OSHPD’s program to look at these outcomes as well. Dr. Carlisle indicated that if by issuing a public report on stroke outcomes,

hospitals and other providers would be given the incentive to raise their level of practice, this in itself would be a good result.

Committee member Hlatky stated that if there is a way to improve the quality of care for patients with stroke, that would indeed be an incredibly important goal. The question is just how do you put something together that might do that. There is the potential for a great contribution if the correct factor to be looked at were to be identified. Dr. Hlatky stated that he was not convinced that an outcome measure is there, except perhaps in some things that are complications that would be preventable, such as bed sores or pneumonia. These are events that are more likely to be preventable in a hospital rather than stating that a patient should be able to walk after a stroke, which may be out of a hospital's control.

Dr. Zingmond added that 5 percent of stroke patients have AMIs and that is part of their stroke complex. There are other things that occur that complicate the clinical course that are not always considered as complications of care.

Dr. Parker mentioned that even though the majority of OSHPD's reports have dealt with 30-day mortality, OSHPD is currently going forward with a maternal outcomes report that for the first time looks at complications, identified through administrative data, and also readmissions. If another measure could be identified with sufficient validity and reliability pertaining to CVA, it might be possible to report on that measure in addition to mortality.

Committee member Hlatky commented that there have been studies done on patient preferences and it is clear that many people feel that there are states worse than death, and some outcomes of stroke are included in those states. "How can we deal with that in terms of an outcomes measure? Is it possible that you might consider a larger set of outcomes?"

Dr. Zingmond stated that quality adjusted life years and function can not be measured. "We can look at longer term outcomes, but the longer you look out, the harder it is to attribute care to the outcome for the initial hospitalization." The patient discharge database is adding elements, but functional status is not one of the new elements. Going forward, if functional status at the time of discharge was added, that would be incredibly helpful for that type of measure, where either the ADLs or the coma score is known.

Chairperson Genna asked as a follow-up what the rationale was for excluding patients from residential care and nursing home facilities.

Dr. Zingmond said that 10 to 15 percent of the patients come from residential care and nursing home the way the information is coded. These patients tend to do worse and they are far more likely to go back to a nursing home or residential care facility. If one aim of the study is to assess if a patient is going to the appropriate care after the event, then going to a nursing home might be an indication that they have poor rehabilitation potential or that they probably will

not recover. So for a more fair comparison, these patients probably should be excluded.

Chairperson Genna asked if there was any exclusion made pertaining to the time issue with this event. For example, a spouse comes home and finds their partner has had a stroke and many hours have elapsed since the event.

Dr. Zingmond stated that there was no way to capture that in these types of data. When it comes to treatment with tPA relatively few patients receive it and there are a number of reasons why, some pertaining to time. For instance, one-third of the patients will suffer a stroke while asleep. But there are structural issues that tie in as well, because a lot of hospitals don't have staff in place who feel comfortable administering tPA for acute stroke and not every hospital has a neurologist that on call for interventions.

Healthcare Outcomes Center Report: Joseph Parker, PhD

Dr. Parker reported that, with respect to the CABG report, an audit of the 2006 hospital inpatient data will begin in 2 weeks. The audit will target 36 hospitals. The primary focus will be hospitals with outlier physicians and/or hospitals for northern and southern California. This winter OSHPD will begin looking at risk adjusted complication rates for heart bypass surgery using the data that has been collected starting in 2006.

Within the administrative data programs, OSHPD's 2003-2005 three-year community-acquired pneumonia report, which does not include DNR as a risk adjuster as was decided at the last TAC meeting, has gone out for a 60-day mandatory hospital review. The deadline for comment letters is December 17, 2007. There is an early draft of the final report completed and OSHPD hopes to have the final report out in January after the administrative review.

The early results show significantly more hospital outliers than in previous years because of the removal of DNR. Previously OSHPD had two models, one with DNR and one without, and only if a hospital was significantly worse or better on both models were they designated an outlier, either better or worse. Now there is only one model without DNR.

There is a completed validation report and final draft of the public report for the Maternal Outcomes report. This is using 1999-2001 data and OSHPD has decided not to release this report until the data has been updated.

OSHPD now has the SAS programs from Dr. Romano and analysis of the information has begun. OSHPD has the data linkage for the OSHPD birth file linkage from 2004 and 2005 and expects to get the 2006 link in December. OSHPD has the basic template for doing the report, but will be contracting with some consulting services as there is a lot of clinical consultation that is necessary regarding exclusion of cases, linking records, anomalies that come

up in the data, and presentation of final results. OSHPD is targeting as a possible release date late summer, 2008.

The AHRQ volume and utilization indicators have been added to the OSHPD website. These indicators include items such as cesarean section delivery rates, primary C-section rates, VBAC rates and other procedures for which over-utilization or under-utilization might indicate differences in quality. There is also a series of volume indicators including esophageal resection, PCI rates, and carotid arterectomy rates, some of which have associated volume outcomes.

There will be a presentation at the California Health and Data Advisory Commission meeting in December regarding the expansion of the patient discharge data. OSHPD has consulted with AHRQ, which is engaged in some related activities. AHRQ is very interested in promoting the idea of extending the patient discharge data to include certain lab values, and other clinical information and is setting up and funding some pilot projects in other states. OSHPD will be joining with those other states to understand the issues that arise as OSHPD moves forward with this project.

OSHPD still has an issue with the definition of time for hospital admission with regard to the clinical data elements. There are usually multiple date/time stamps that are on the face sheet and these can differ quite a bit. There has to be a consistent definition where OSHPD can put a time window around allowable values. This definition would also be needed for data audits.

With regard to lab values specifically, OSHPD feels it is premature to expect automated submission of lab values with the patient discharge records. This is an area where OSHPD will be working with some of the hospital IT lab staff.

Vitals signs have the same time issues, do you get the first one, the most severe, on arrival or at the bedside?

In terms of the operating physician identifier, the number of procedures for which that data element is collected needs to be narrowed to predominately therapeutic procedures rather than diagnostic procedures. But there are some diagnostic procedures that have complications associated with them that OSHPD may want to include. The attribution of who the responsible physician is will be difficult, because there does not seem to be a standardized way of recording that kind of information and there can be multiple physicians involved.

The Patient Profile Report which explores the relationship between emergency department data, ambulatory surgery data and patient discharge data will be developed as a web presentation for the OSHPD website and possibly a hard-copy fact book.

Lastly, OSHPD is beginning to look at the AHRQ patient safety indicatiors. AHRQ developed 20 of these measures that provide information on potential in-hospital complications and patient safety concerns following surgeries, other

procedures and childbirth. They use the ICD-9 data that OSHPD has in the patient discharge data. OSHPD is doing quite a bit of analyses to try and see whether there are some measures that would meet OSHPD's criteria which could open new possibilities for reporting.

The meeting adjourned at 1:05 p.m.

The next AB 524 meeting is to be announced.

Pending:

1. Updated analysis of the abdominal aortic aneurysm repair report focusing on volume analyses as requested by Dr. Brook.